Additional Questions and Answers
July 2002

ACR

Note: Additional Q&As on ACRs can be found at:
http://www.hcfa.gov/medicare/acrp.htm.

Q: An M+C organization wants to offer two options. One option would have a $1000 prescription drug limit and the other would have a $1500 prescription drug limit with everything else being the same. Should we file two ACRs or should we file one ACR with an optional supplemental benefit?

A: The M+CO should file one ACR with the additional drug coverage as an optional supplemental benefit. The $1000 maximum drug coverage would be included in the ACR and PBP as an additional or mandatory supplemental benefit. The additional $500 of drug coverage would be included as an optional supplemental benefit.

PBP

1. Q: Will a PBP patch be provided to all plans and if so, what is this "patch"?

   A: The patch was provided to HPMS users on July 9, 2002. The PBP patch is a small piece of software aimed at updating the SB files. The patch will need to be saved in the same directory as your current PBP software. If you have any difficulties with installing the patch please contact the HPMS help desk at 1-800-220-2028.

2. Q: We heard that the current PBP software on HPMS does not have the Summary of Benefits file programmed in 12-point font. As a health plan, we want to meet the timelines established with the changed ACR submission deadline, and one way to do this would be to be able to print the SOB from the PBP software or download the file to be used as a 'model SOB'. Will CMS reprogram the PBP/SOB file to meet the same 12-point font requirement that health plans are held accountable to?

   A: The SB export is not meant to be print ready. The executable is provided to assist plans with putting together the final SB. This year, we have enhanced the executable. Please see the on-line help for this information.

Marketing

1. Q: Now that the agency's name has changed to the Center for Medicare & Medicaid Services (CMS), how should MCOs handle the name in their marketing materials?

   A: For any marketing material that has not yet gone to print, the MCO (this includes all types of Medicare managed care entities, not just M+C organizations) should change all references to "HCFA" to now read "CMS." The MCO may also indicate

somewhere on the marketing material that CMS was "formerly called Health Care Financing Administration," or "formerly called HCFA."

For any material that is already in use/in print, we expect the MCO to change all references to "HCFA" to be "CMS" when the material is next updated or printed.

2. Q: If the M+CO sends the ANOC out with the disclaimer, does the M+CO have to re-send the ANOC to members when the ACR is approved?

   A: M+COs will only need to re-send the ANOC (or an addendum) to members if the approved ACR differs from the submitted ACR (i.e., if the information in the ANOC is no longer correct).

Nonrenewals

1. Q: You are asking for Partial county non-renewals by August 15th. Does this deadline apply to only partial county non-renewals? Do we have until September 17th if we decide to terminate a whole county?

   A: If a partial county service area reduction is requested by August 15 and it is approved or denied, an organization has until September 17, 2001 to notify CMS it intends to withdraw from the entire county. An organization can also advise by September 17 that it wants to withdraw its requests for a partial county and remain in the county in 2002.

2. Q: If we plan to non-renew, where should we send our notice of non-renewal?

   A: Any notice of non-renewal must be sent by September 17 to the following address:

   Mr. Gary Bailey
   c/o Ms. Lettica Ramsey
   Centers for Medicare & Medicaid Services
   Center for Beneficiary Choices, Health Plan Benefits Group
   C4-23-07
   7500 Security Boulevard
   Baltimore, MD 21244

3. When will CMS post the 2002 Medicare Managed Care non-renewal instructions and beneficiary notification letter on its website?

   A. The 2002 Medicare Managed Care Non-renewal instructions and Model Beneficiary notification letter will be posted on the CMS website in early August.

4. Q: Are non-renewal notices considered marketing materials that are subject to the review period rules for marketing materials?

A: Non-renewal letters (also known as non-renewal notices) are considered to be marketing materials. However, non-renewal notices are subject to the rules outlined in the non-renewal procedures, which require an expedited, priority review and approval process in order to meet specific regulatory due dates.

Encounter Data

1. Q: Do M+COs need to continue to collect UPINs?

   A: On May 25, Secretary Thompson suspended the collection of physician and hospital outpatient encounter data through July 1, 2002. Therefore, M+COs do not need to continue to collect UPIN information.

Enrollment

1. Q: What are the M+C enrollment effective date rules for the months of November and December 2001?

   A: The month of November is the Annual Election Period (AEP), during which time all M+C plans must accept enrollments unless they have an approved capacity limit and have met that limit. AEP elections this year are effective January 1, 2002. In addition, because M+C plans can be continuously open through 2001, the month of November will also be part of the OEP for plans that choose to be open. Because the AEP and OEP will overlap in November for these plans, the M+CO must allow the individual to choose the election period (and therefore the effective date) in which s/he is enrolling. If the beneficiary chooses to make his/her election during the OEP, the effective date would be December 1, 2001. If the beneficiary does not choose an election period/effective date, the M+CO should assign a January 1, 2002 effective date. If an M+C plan is not open for OEP elections, then beneficiaries can only enroll through the AEP for a January 1, 2002 effective date.

   For the month of December 2001, we have established a Special Election Period (SEP) for all beneficiaries for which elections will be effective on January 1, 2002. As with the AEP, all M+C plans must accept enrollments during this SEP, unless they have an approved capacity limit.

2. Q: Will the model M+C enrollment form be revised? If so, when will it be made available to M+COs?

   A: Yes, several of the model forms and letters from the exhibits of OPL 99.100 are currently being updated to reflect the new "lock-in" rules for 2002, including the model enrollment form. We plan to release the revised models in August 2001.

Cost Plans

1. Q: Cost plans do not submit ACRs. Does a cost plan have to put the disclaimer, "pending Federal approval" on the ANOC and SB when a formal notice of approval is never received?

   A: No, cost plans should not use this disclaimer.

2. Q: Will a revised ANOC for cost plans be provided?

   A: No. We do not plan to provide a separate model ANOC since the model contained in OPL 132 will suffice for cost plans.

3. Q: When will SB instructions for cost plans be provided?

   A: The instructions should be available some time this month (July).

4. Q: When must cost plans send the ANOC? When must they send notice of nonrenewal.

   A: All members of cost plans must learn of changes 30 days prior to the change. Thus, the date the (cost plan) ANOC must be in members' hands is December 1, 2001.

   All members of non-renewing cost plans must learn of the non-renewal 60 days prior to the non-renewal. Thus, the cost plan non-renewal letters must be mailed in members' hands November 1.

Miscellaneous

1. Q: How does the agency set the capitation rate for M+COs. Specifically, to what extent do financial data reported by M+COs factor into the determination?

   A: Congress, through the Balanced Budget Act of 1997 (BBA), established the basic formula to set M+C payment rates. The BBA mandated that reimbursement to M+C organizations would be the greater of three sums: a 2 percent increase over their previous year's payment; a blended payment that combines local health care cost increases with the national average health care cost increase; or a minimum payment "floor" (for all periods following February 28, 2001, Congress established two floors - one for large MSAs and one for all other payment areas).

   Certain demographic and health status data are submitted by M+C organizations, which modify CMS's actual payments to the organization.

   For the most part, financial data submitted by the M+C organizations are used to set the premiums and cost sharing amounts to be charged to the Medicare beneficiary electing the M+C plan.

2. Q: There has been discussion between various plans on the appropriate CMS policy that should be followed related to Medicare members. Some plans have interpreted that waiver of copayments for Part B are required for Medicare members and other plans have interpreted that waiving copyaments for Medicare members violates other guidance that has been provided that requires that all members who enroll in an M+C plan be provided with the same set of benefits and that a copay waiver was not allowed for a subset of the population unless the plan decided to waive the copay for all its members uniformly.

   A: §42CFR422.304(b) of the regulations outlines the CMS policy on uniformity. Basically, the M+C organization must charge each Medicare enrollee (or someone on behalf of the beneficiary), electing a specific M+C plan, the same premium and must set a uniform level of cost sharing. Waiving cost sharing amounts for a subset of the M+C plan's population would violate the uniformity principles of §42CFR422.304(b).

   This does not preclude the M+C organization from charging someone else on behalf of the beneficiary. For example, some Medicare enrollees are eligible to receive Medicaid benefits in addition to Medicare benefits. In this case, the M+C organization may negotiate with the State or local Medicaid authority to pay a portion or all cost sharing for the Medicare beneficiary. It is not required to have payment made at the time a service is furnished. Rather, the M+C organization may adjust premiums and other charges paid by the State or local Medicaid authority to account for the lower cost sharing amounts being charged to the beneficiary. For further information, see §42CFR422.106.